Boulder Community Health
Ambulatory Services Department

***Clinic Name*:_____*Provider*:_____**

Federal Legislation now provides incentive progams for physicians that can demonstrate they are using Electronic Health Records in ways that can improve quality, safety and effectiveness of care.

In order to qualify for those payments, this clinic must collect demographic information from our patients including your race, ethnicity and primary languge. This information is collected soley for governement reporting purposes. It will not be used by this clinic or by Boulde r Community Hospital. Patients may decline to provide this information.

The same legislation also mandates that the patients be provided with a clinical summary of your office visit that provides relevant information specified in that law. You will receive that visit summary within 3 business days of your office visit.

Patient Name Last:_____ First:_____ MI:_____ DOB:_____

Race: *(Circle One)*	**Ethnicity**: *(Circle One)*	**Preferred Language**: *(Circle One)*	**Preferred Contact**: *(Circle One)*
Amer. Indian/Alaska Native	Hispanic	Arabic	Email_____
Asian	Non-Hispanic	Chinese	Fax
Black/African Amer.	Declined	English	Mail
Pac Isle		French	Web Portal
White		German	Phone_____ Cell/Home/Work
Declined		Spanish	Text
Other		Other:_____	

Boulder Community Health
Ambulatory Services Department

***Clinic Name*:_____*Provider*:_____**

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Patient Name Last:_____ First:_____ MI:_____ DOB:_____

Race: *(Circle One)*	**Ethnicity**: *(Circle One)*	**Preferred Language**: *(Circle One)*	**Preferred Contact**: *(Circle One)*
Amer. Indian/Alaska Native	Hispanic	Arabic	Email_____
Asian	Non-Hispanic	Chinese	Fax
Black/African Amer.	Declined	English	Mail
Pac Isle		French	Web Portal
White		German	Phone_____Cell/Home/Work
Declined		Spanish	Text
Other		Other:_____	

Boulder Community Health
Ambulatory Services Department

***Clinic Name*:_____*Provider*:_____**

Communication of Personal Medical Information

Please provide us with the telephone number you would like us to use when contacting you with medical information follow ups, such as results of tests, etc.

Patient Name:_____ Date of Birth: _____
(please print)

Primary Phone: _____ Secondary #: _____

Voice Mail: (check one)

- ❒ I prefer only minimal notification be left on voice mail (who called, where they are calling from, and a number where they can be reached).
- ❒ I give permission to the clinic to leave messages, with discretion, of non-critical results and general medical information on voice mail for the number(s) listed above.
- ❒ I do not wish to have messages left on voicemail.

Disclosure to Other Persons: Please complete the BCH HIPAA Release of Information form if you would like any of your health information to be disclosed to an individual other than yourself.

- ❒ I do not authorize the release of information to any other individuals.
- ❒ I have completed the BCH HIPAA Release of Information.

_____ _____
Signature of Patient or Legal Guardian **Date:**

Boulder Community Health
Ambulatory Services Department

HIPAA Release of Medical Information from BCH

Patient's Name: _____ **DOB**: _____

INFORMATION RELEASE TO OTHER PERSONS AUTHORIZATION: I authorize the release of any of my medical information either over the phone or through the MyBCH Clinic Patient Portal, to the following individuals:

1. _____ Relationship: _____
2. _____ Relationship: _____

RELEASE RECORDS ☐ **To** ☐ **From** ☐ **To** ☐ **From**

Clinic Address Stamp

Name:_____

Phone:
_____

Address:
_____

_____

Fax:
_____

GENERAL AUTHORIZATION: I authorize the above-named health care provider to release the information specified below to the organization/agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by appropriate practitioner.
I understand that BCH may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be re-disclosed by the recipient and is no longer protected by privacy laws.

SPECIFIC AUTHORIZATION: I specifically authorize the release of information regarding the following conditions:

- ☐ Alcohol/Drug abuse information – I understand that my chemical dependency records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CRF, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (see reverse side for re-disclosure prohibition)
- ☐ Psychosocial/ Psychiatric information: (excludes psychotherapy notes which require separate release)
- ☐ Other: _____

INFORMATION REQUESTED:

- ☐ Complete copy of medical record (most recent 2 years)
- ☐ History and physical exam
- ☐ Discharge summary
- ☐ Treatment plan
- ☐ Admitting psychiatric assessment
- ☐ Emergency department record
- ☐ Other _____
- ☐ Operative reports, consults
- ☐ Laboratory reports
- ☐ Imaging reports
- ☐ EKG
- ☐ EEG
- ☐ Providers orders & progress notes
- ☐ Nurses' notes
- ☐ Therapy notes & dictation
- ☐ Psychological eval (excludes psychotherapy notes)
- ☐ Neuropsych/Psych. testing & evals (does not include raw data or psychotherapy notes)

CONDITIONS AND DATES OF CARE COVERED:

- ☐ Regarding these treatment dates and/or for conditions: _____
- ☐ All admissions or care at this facility provided as of the date of my signature:

Boulder Community Health
Ambulatory Services Department

PURPOSE(S) FOR WHICH INFORMATION IS TO BE USED:

- ☐ Further eval/treatment
- ☐ Insurance/reimbursement
- ☐ Legal
- ☐ Verify Treatment Status
- ☐ Personal use
- ☐ Worker's Compensation
- ☐ Other (specify) _____

EXPIRATION OR REVOCATION OF AUTHORIZATION:

I understand that I may revoke this authorization at any time, except to the extent that action has already been take to comply with it. Without my previous expressed revocation, this authorization will automatically expire one year from the date of my signature unless noted below.

- ☐ On _____
- ☐ No longer than _____ days from the date of my signature or under the following conditions: _____
- ☐ Upon fulfilling the purpose or need for information as specified above, but no longer than _____ days from the date of my signature.
- ☐

NOTE: Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

SIGNATURE: A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's Signature (if 18 years of age or older) _____ Date: _____

If patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

Authorized Representative Name (please print): _____

Authorized Representative Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

In accordance with 42 C.F.R. Section 2.13 , any disclosure of information from a federally assisted drug or alcohol abuse program must be limited to that information which is necessary to carry out the purpose of disclosure.

Pursuant to 42 C.F.R. Section 2.32, the following statement on the prohibition of re-disclosure must accompany each disclosure made with the patient's written consent:

Prohibition on Re-disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Regulations for patient medical record reproduction fees

Standards for hospital and health facilities 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4; Adopted by the Board of Health on May 16, 2001; Effective June 30, 2001 The discharged patient or representative shall pay for the reasonable cost of obtaining a copy of his/her patient record.

Boulder Community Health
Ambulatory Services Department

Clinic Name*:**_____Provider*:**_____

Financial Policies

Please read and sign, indicating your understanding of the following information. If you have questions please do not hesitate to ask. It is important that you understand these specific policies of the Boulder Community Hospital Physicians' Clinics and that you understand how your insurance company will handle your claims.

_____ **It is your responsibility to provide the office with current and correct insurance information.** Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

_____ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** The clinics participate with most major medical insurance companies. However, Insurance companies frequently specify the time frame in which patients can be seen and the coverage widely varies group to payor. If appointments are made that are not covered by your insurance plan, you will be responsible for payment.

_____**We do not always know if you have a deductible, if your deductible has been met, or if you have co-insurance.**. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

_____ **You will need to sign a self-pay waiver if you have no insurance.** This waiver clarifies your financial responsibility and helps prevent misunderstandings.

_____ **Discounts are offered on some medical services, but ONLY if you pay at the time of service**. If you have no insurance, or if you are receiving services that are not covered by your insurance plan, you may be eligible for a discount on ***some medical services***. Payment must be made at the time of service for the discount to apply. The front office staff can let you know if the services you are receiving qualify for the discount. It is your responsibility to ask the front office for the discount.

_____ **If you have a co-pay, you are expected to pay this when you check in for your visits.** Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take checks, cash, and credit cards. Be prepared to pay your co-pay when you check in for **each** visit.

_____ **You will be charged if you fail to show up for your appointment or if you cancel your appointment with less than 24 hours notice.** Exceptions may be made for inclement weather. The correct number to call when canceling an appointment is 303-441-2347.

_____ **There may be services that are initiated during a clinic visit that are <u>not</u> performed on-site and are <u>not</u> billed by the clinic directly** (for example, most laboratory, pathology, and radiological diagnostic services). When services and diagnostics are sent out to a third party, you will receive a separate bill from that third party directly for any patient balance that is due. If you want additional information, it is your responsibility to ask at the time of service, whether services are being sent out and to whom they are being sent.

_____ **I consent to be contacted by regular mail, e-mail, or telephone (including wireless/cell number) regarding any matter to my account(s).** This consent applies to all BCH healthcare providers and/or any entity working on behalf of BCH. This consent includes any updated or additional contact information that I may provide, and includes phone calls that employ auto-dialer technology and prerecorded messages. If I wish to revoke this consent, I agree to provide notice of that revocation by contacting BCH Patient Financial Services at 303.415.4766

I understand that BCH Physician's Clinics will need to use and disclose certain medical information about me as it relates to my treatment, payment for treatment, and healthcare operations. I have been provided with a notice that describes how my medical information may be used and disclosed and how I can access this information.

_____ _____

Signature of Patient or Legal Guardian **Date**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Who will Follow this Notice

- Health care practitioners who treat you at any of Boulder Community Hospital's locations, including employees, volunteers, and members of the Hospital Medical Staff,
- All departments and operating units of our organization,
- All medical practices operated by the Boulder Community Hospital ("BCH").

Rather than have you read and sign different notices for each health care practitioner that treats you at each of our operating locations, this Joint Notice of Privacy Practices describes the privacy practices followed by all our practitioners, other members of our workforce, and our business associates.

Unless your physician is affiliated with one of the BCH medical practices, this notice does not apply to the use and disclosure of your medical information in connection with treatment you receive at your physician's office. Your personal physician may have different policies regarding your medical information and may provide you with a separate notice. If your physician is affiliated with one of the BCH medical practices, this notice will apply to your medical information created or maintained at that office.

Your Medical Information.
This notice refers to your "medical information". This means all information that identifies you and relates to your past, present or future physical or mental health or condition including information about payment and billing for the health care services you receive.

Our Pledge Regarding Medical Information

We understand that your medical information is personal and we are committed to its protection. We create a record of the care and services you receive to ensure that we are providing quality care and to comply with legal requirements. This notice applies to all your medical information that we maintain, whether created by our staff or others.

We are required by law to give you this notice of our legal duties and privacy practices with respect to your medical information, to follow the terms of this Privacy Notice, and to notify you following a breach of the privacy or security of your unsecured medical information.

How we may Use and Disclose Medical Information about You

For each category of use and disclosure, we will try to give some examples, although not every use or disclosure in the category will be listed.

For treatment. We may use your medical information so that we and other health care providers may provide you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow your healing. Also, the doctor may need to provide information to the dietician so we can arrange for appropriate meals.
Different health professionals may also share your medical information in order to coordinate the different services you need. We may disclose your medical information to people outside the hospital who may be involved in your medical care after you leave the hospital.

For payment. We may disclose your medical information so that treatment and services you receive may be billed by BCH or other health care providers to a third party. For example, your health plan may need to know about surgery you received so they will pay us for the surgery. We may also disclose your medical insurance information to obtain prior approval from your health plan.

For Health Care Operations purposes. We may use and disclose your medical information for our internal operations, such as business management, and administrative activities, legal and auditing functions, and insurance-related activities. We may use medical information to make sure that all of our patients receive quality care, such as reviewing our processes or to evaluate the performance of those caring for you. We may also disclose information to doctors, nurses, technicians, and other personnel for review and learning purposes. We may remove information that identifies you from this set of information so others may use it to study healthcare and healthcare delivery without learning a specific patient's identity. Under certain circumstances, we may disclose your medical information for the health care operations of other health care providers.

Health Information Exchange.
BCH participates in the Colorado Regional Health Information Organization ("CORHIO") which arranges for the electronic exchange of health information among health care providers in Colorado. BCH may exchange your health information electronically through CORHIO for the purposes described in this Notice. You have the right to request that your information not be included in this exchange.

Hospital Directory. We may disclose certain information about you in the hospital directory while you are a patient. This is so your family, friends, and clergy can visit you at BCH and generally know how you are doing. Limited information such as your name, location in the hospital, your general condition, (e.g. fair, stable, etc.) and religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy even if they do not ask for you by name. You may request to be a confidential patient and not be included in the Hospital Directory. If you choose to do this, no information will be given to any of the above-mentioned people, and your name will not be listed in our directory.

Individuals Involved in your Care or Payment of your Care. We may release your medical information to a friend or family member who is involved in your medical care, or to someone who helped pay for your care.

Notification. We may release your medical information to notify a family member, personal representative or another person responsible for your care of your location, general condition, or death. We also may release your medical information for certain disaster relief purposes.

Contacts. We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Fundraising Activities. We may contact you in an effort to raise money for BCH. We will only use limited information, such as your name, address, and dates of service. With each fundraising communication, you will be notified of your right to opt out of receiving these communications in the future. If you do not want us to contact you, you must notify our Privacy Officer in writing at the address below.

Worker's Compensation. We may release medical information about you for worker's compensation or similar programs, which provide benefits for work related injuries or illnesses.

Mental Health Information. State laws create specific requirements for the release of mental health records. BCH will obtain your specific authorization to release mental medical information when required by these laws.

Drug and Alcohol Treatment Records. Specific rules apply to the release of certain drug and alcohol program records, and BCH will obtain your specific authorization to release those records as required by Federal regulation 42 CFR, Part 2.

Miscellaneous. We may use or disclose your medical information without your prior authorization for several other reasons. Subject to certain requirements, we may give out your medical information without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, Coroner's investigations, organ donation, and emergencies. We also may disclose medical information when required by law in response to a request from law enforcement in specific circumstances, for specialized government functions including correctional, military or national security purposes, in response to valid judicial or administrative orders or to avoid a serious health threat. Additional specific rules may apply to mental health records.

Other Disclosures. *Other uses and disclosures not described above will be made only with your written authorization*. For example, we require your signed authorization for uses and disclosure that constitute the sale of your medical information and for most uses and disclosures of psychotherapy notes. Additionally, we will not use or disclose your medical information for marketing purposes unless we have a signed authorization from you except that an authorization will not be required if (i) a communication occurs face-to-face; (ii) consists of marketing gifts of nominal value. *You may revoke your authorization at any time unless we have relied on your authorization or your authorization was required as a condition of obtaining health care services*.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy. In most cases you have the right to inspect or receive a copy of your medical information (or have a copy provided to an individual whom you designate) when you submit a written request. If your medical record is maintained electronically in a designated record set, you have the right to request a copy of the information in an electronic form and format. We may deny your request in certain circumstances. If you are denied access to your medical information, you may appeal.

Right to Amend. If you believe the information in your record is incorrect or incomplete, you have the right to request an addendum be added to your record by submitting a written request giving your reason. We may deny your request under certain circumstances. If we deny it, we may advise you in writing of the reason or explain your rights to submit a statement of explanation.

Right to an Accounting of Disclosure. You have the right to a list of those instances where we have disclosed your medical information other than for treatment, payment, healthcare operations, or where a disclosure was specifically authorized., for the Hospital's directory, to persons involved in your care, and certain other limited situations. To request an accounting of disclosures, you must submit a written request to our Privacy Officer.

Right to a Paper Copy of this Notice. If this joint notice was sent to you electronically you have a right to a paper copy of this notice.

Right to Request Restrictions. You may request in writing that we not use or disclose your medical information except when specifically authorized by you, when required by law, or in an emergency. Except in the case of certain requests related to disclosures to health plans, we are not required by law to agree to your request, but we will consider the request. We will inform you of our decision.

Right to Request Restrictions on Disclosures to Health Plans. You may request in writing that we restrict disclosures of your medical information to a health plan for purposes of carrying out payment or healthcare operations if the disclosure is not required by law and the medical information pertains solely to a health care item or service for which you (or a person other than the health plan who is acting on your behalf) have paid BCH out of packet and in full at the time of service. We must agree to a request that meets these requirements.

Changes to this Notice.

We reserve the right to change this notice at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. We will post a copy of our current notice within our facilities and we will post it on our website at www.bch.org.

Complaints and Requests

If you have questions about this notice or want to talk about a problem without filing a formal complain, please contact the Boulder Community Hospital Privacy Officer at the following number 303-440-2342.

If you believe your privacy has been violated, you may file a complaint with the Boulder Community Hospital organization or with the Secretary of the Department of Health and Human Services. All complaints or requests must be submitted in writing to:

Boulder Community Hospital
P.O. Box 9019
Boulder, CO 80301-9019
Attn: Privacy Officer
(Phone # 303-440-2342)

Information about how to file a complaint with the Department of Health and Human Services may be found at the following website:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

You will not be penalized for filing a complaint.

Signature _____

Date _____

Boulder Community Health
Ambulatory Services Department

Clinic Name:_____ Provider:_____

Patient Fall Assessment

Name_____ **Date**_____

DOB_____

Please complete for all new patients and patients 65 or older, have recently experienced a fall, or feel you are at risk for a fall.

Fall Assessment

1. Have you fallen more than once in the past year?
   ❒ Yes ❒ No

2. Have you experienced a stroke or other neurological problems that have affected your balance?
   ❒ Yes ❒ No

3. Do you feel unsteady when you are walking or climbing stairs?
   ❒ Yes ❒ No

4. Are you currently taking any medications that may affect your balance?
   ❒ Yes ❒ No

Boulder Community Health
Ambulatory Services Department

Clinic Name:_____ Provider:_____

Nutritional and Learning Needs

Name_____ **Date**_____

DOB_____

Nutritional Assessment

1. Have you experienced unexplained weight loss?
☐ Yes ☐ No

2. Are you a newly diagnosed diabetic?
☐ Yes ☐ No

3. Are you experiencing nausea, diarrhea or vomiting?
☐ Yes ☐ No

4. Would you like to speak to someone about a nutritional consult?
☐ Yes ☐ No

Learning Needs Assessment

Are there any factors or needs that you feel may influence your ability to learn, and may interfere with meeting your treatment or plan of care?

Check all that apply:
□ Physical Limitations
□ Language Barrier
□ Cognitive Limitations
□ Religious/Cultural Practices
□ Emotional Barrier
□ Desire/Motivation
□ Literacy
□ Pain/Discomfort
□ Financial Implications
□ None
□ Other: _____.

I learn best by: Check all that apply

□ Visual (Video)
□ Reading (Written Material)
□ Doing (Examples)
□ Listening (Verbal Tapes)
□ N/A

Primary Language Spoken: _____

Patient Initials:_____ Date:_____

Boulder Community Health

Medical History Questionnaire

Name:	**DOB:**
Reason for Visit:	
Primary Care Physician:	

Past Medical History - Please check all that apply

Abdominal Pain	☐	Drug Abuse	☐	Irritable Bowel Syndrome	☐
Abortion	☐	Elevated PSA	☐	Liver Disease	☐
AIDS/HIV	☐	Emphysema	☐	Migraine	☐
Alcoholism	☐	Epilepsy	☐	Mononucleosis	☐
Anemia	☐			Osteopenia	☐
Angina	☐			Osteoporosis	☐
Appendicitis	☐	Gastic Ulcer	☐		
Arthritis	☐	GERD/Acid Reflux	☐		
Asthma	☐	Glaucoma	☐		
Blood Clots/DVT/PE	☐	Goiter	☐	Pneumonia	☐
Cancer:	☐	Gout	☐	Polio	☐
Cataract	☐			Rectal Bleeding	☐
Chest Pain	☐	Heart Disease	☐	Shortness of Breath	☐
Chronic Kidney Disease	☐	Hemorrhagic Condition	☐	Stroke/TIA	☐
Chronic Pain	☐	Hepatitis	☐	Transfusions	☐
Colon Disorders/Polyps	☐	Hernia	☐	Tuberculous Infection	☐
Diabetes Type I	☐	Herpes Simplex	☐	Other:	☐
Diabetes Type II	☐	Hypercholesterolemia	☐	Other:	☐
Disorder of the Thyroid	☐	Hypertension	☐	Other:	☐
Depression/Anxiety	☐				

Date/Location of last Colonoscopy:	**Date/Location of last Mammogram:**

Vaginal Infections - History of:

Hospital Admissions/Surgeries (excluding pregnancy)

Year	Description	Year	Description

Care Team Members (List other healthcare providers & location)

Current Medications

Medication	Dose	Medication	Dose

Contraceptive (Birth Control) Method

Current: Past:

Allergies

Drug Allergies & Reaction	Food/Other Allergies & Reaction

Family History

Have any of your close relatives had any of the following conditions?

Condition	Type	Relation to you	Maternal/Paternal	Age Diagnosed
Blood Disorder ☐				
Cancer ☐				
Diabetes ☐				
Heart Disease ☐				
High Blood Pressure ☐				
Stroke ☐				
Kidney Disease ☐				
Lung Disease ☐				
Other: ☐				

Social History

Feels safe at home	Yes ☐	No ☐	Caffeine	Yes ☐	No ☐
Seatbelts used	Yes ☐	No ☐	Tea/Coffee _____ cups/day		
Hearing aids	Yes ☐	No ☐	Colas _____ cans/day		
Vision Impaired	Yes ☐	No ☐	Tobacco	Yes ☐	No ☐
HIPAA Privacy available	Yes ☐	No ☐	Never ☐	Former ☐ Quit date_____	
Speak up brochure available	Yes ☐	No ☐	Current ☐ #/type per day_____		
Out of country in last year	Yes ☐	No ☐	Exercise	Yes ☐	No ☐
Alcohol - Drinks/week_____	Yes ☐	No ☐	Activity per week:_____		
Street Drugs	Yes ☐	No ☐	Sexually active	Yes ☐	No ☐

Signature:_____ Date:_____

Boulder Community Health
Ambulatory Services Department Clinic Name:_____ Provider:_____

MSP Questionnaire (for Medicare Patients)

Patient Name: _____ Date of birth: _____ Date: _____

1. Are you receiving **Black Lung (BL) benefits**? ___ No ___ Yes*
2. Are any of your services to be paid by a **government research grant**? ___ No ___ Yes*
3. Are any of your services to be paid for by the **Dept of Veteran Affairs**? ___ No ___ Yes*
(Requires authorization from the VA to be seen at this clinic)
4. Are any of your services due to a work-related illness/injury for which a **Worker's Compensation** plan must be billed? ___ No ___ Yes*
5. Are any of your services due to an **automobile accident**? ___ No ___ Yes*

---

6. **Are you entitled to Medicare based on your age (65 and over)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Are you currently **ACTIVELY** employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   (**If NO,** what is your retirement date _____)
   - Are you covered by your employer's group health plan? ___ No ___ Yes*
   - Does your employer employ 20 or more people? ___ No ___ Yes*

   b. Is your spouse currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by your spouse's employer's group health plan? ___ No ___ Yes*
   - Does your spouse's employer employ 20 or more people? ___ No ___ Yes*

---

7. **Are you entitled to Medicare based on disability**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Are you currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by your employer's group health plan? ___ No ___ Yes*
   - Does your employer employ 100 or more people? ___ No ___ Yes*

   b. Is a family member (parent or spouse) currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by the family member's employer's group health plan? ___ No ___ Yes*
   - Does your family member's employer employ 100 or more people? ___ No ___ Yes*

---

8. **Are you entitled to Medicare as a result of ESRD (End Stage Renal Disease)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Do you have group health plan coverage? ___ No ___ Yes
   b. Are you within the 30 month "coordination" period? ___ No ___ Yes
   If YES to both a and b, please answer the following questions:
   - Are you entitled to Medicare based on ESRD and age (65+)? ___ No ___ Yes

   If YES, please answer the following question:
   - Was your initial entitlement to Medicare based on age (65+)? ___ No ___ Yes
     *** If YES, please make sure to complete section 6, above ***
   - Are you entitled to Medicare based on ESRD and disability? ___ No ___ Yes

   If YES, please answer the following questions:
   - Was your initial entitlement to Medicare based on disability? ___ No ___ Yes
     ***If YES, please make sure to complete section 7, above ***

Patient Signature:_____